Embassy of the United States of America
Oslo, Norway

INSTRUCTIONS FOR MEDICAL EXAMINATION

All immigrant visa applicants must undergo a medical examination in Norway.

Applicants fifteen (15) years of age and older must have a chest X-ray (unless pregnant), and a serological test for syphilis and HIV, in addition to a general medical evaluation. These tests must be performed at designated facilities in Norway. In addition the vaccination requirements explained below must be met.

Applicants under fifteen (15) years of age only need a general medical examination and necessary vaccinations, unless the examination reveals the need for further tests.

Chest X-ray and Blood Tests

The X-ray examination and the serological tests for syphilis and the HIV antibody must be done in Norway at the facilities specified in the accompanying documents. The chest X-ray examination and the serological (blood) test must be taken less than 90 days before your general medical examination by the panel physician. The results of the tests are sent directly to the panel physician - allow time for them to reach the panel physician before your appointment with him. The medical certificate from the panel physician's examination must be less than one year old before you appear for your visa interview at the Embassy.

Each person having an X-ray and blood test **MUST PROVIDE PHOTO-IDENTIFICATION TO THE LABORATORY TECHNICIANS (PASSPORT PREFERRED.)**. Please have the technicians sign the enclosed sheet after having written down the photo-ID that was presented. **Give the completed sheet to the panel physician at the time of your physical examination.**

To obtain the chest X-ray, you must take the attached medical prescription form to any of the Sentrum Røntgeninstitutt facilities listed on the form or any hospital (but not to a private clinic.). The technician must send the results, including an evaluation, directly to the panel physician. The technicians should give the X-ray film directly to you and you should pack this in your carry-on luggage when you travel to the United States.

Chest X-ray: Sentrum Røntgen Institutt:

Avd. Oslo Storgaten 8 0155 Oslo 22 20 71 10	Avd. Oslo Kr. Augustsgt. 19 0164 Oslo 22 20 23 24	Avd. Oslo Grønnegt. 10 0350 Oslo 22 60 35 95

Avd. Lillestrøm Nittedalsgt. 2B 2000 Lillestrøm 63 81 80 26	Avd. Bergen Bergen Storsenter Vincens Lunges gt. 3 5015 Bergen 55 56 08 80	Avd. Trondheim Kjøpmannsgt. 17 7013 Trondheim 73 52 51 80	Avd. Stavanger Børehaugen 1 4006 Stavanger 51 89 61 22

HIV Blood Test

A blood test for the antibody to the Human Immunodeficiency Virus (HIV) is required as part of your medical examination for those 15 years or older. HIV is the virus that is the cause of the Acquired Immune Deficiency Syndrome (AIDS). AIDS is the name given to a group of illnesses that may occur in persons infected with HIV. Infection with HIV causes a defect in a person's natural immunity against disease. This defect leaves infected people vulnerable to serious illnesses that would not usually be a threat to anyone whose immune system was intact. This test is not to diagnose AIDS, and it does not necessarily mean that you have AIDS or will get it.

To obtain the blood test, you can go to your own physician or any laboratory, however you must use the prescription form from the panel physician, included with these instructions. Fill in your name, birth date, etc. The results should be returned directly by the laboratory to the panel physician at the address indicated**.** If the test for HIV is positive or inconclusive, it must be repeated so that a definite result is obtained.

The results of your test are provided to a consular officer. Also, it may be necessary to report results to health authorities in this country.

A positive test result means that you will not be eligible to receive a visa, but may be eligible for a waiver. A positive test result could also have other consequences on your day-to-day activities in this country.

Vaccination Requirements

All immigrant visa applicants are required to obtain certain vaccinations prior to the issuance of the immigrant visa. You may need to have one or more of the vaccinations listed below, depending on your age. The panel physicians who conduct medical examinations of immigrant visa applicants are required to verify that applicants have met the vaccination requirements, or that it is medically inappropriate for the visa applicant to receive the required vaccinations. If born after 1956, Diphtheria/Tetanus (received during the last 10 years) and MMR are always required. The other listed vaccinations may be required for specific age groups. The panel physicians can give you more information. If you wish you can ask the nurse for details at the time of making the appointment.

**Mumps*	**Measles*	**Rubella*
**Polio*	Pertussis	Tetanus and diphtheria toxoids
Hepatitis B	**Varicella*	Influenza type b (Hib)

* Contraindicated for pregnant women and immune-deficient individuals.

In order to assist the panel physician and avoid delays in the processing of an immigrant visa**, all immigrant visa applicants should have their vaccination records available for the panel physician to review** at the time of the immigrant medical examination. (Note*: if you wish, you may fax your vaccination records to the panel physician for review.*) Visa applicants should consult with their regular health care provider to obtain a copy of their immunization records, if one is available. If you do not have a vaccination record, the panel physician will work with you to determine which vaccinations you may need to meet the requirements. Certain waivers of the vaccination requirement are available upon the recommendation of the panel physician.

It is recommended that you have all vaccinations up-to-date before you see the panel physician. Although he can administer some vaccines, he does not have all of them in stock. The panel physician charges an extra fee for administering vaccines.

Only the panel physicians can determine which of the listed vaccinations are medically appropriate for you, given your age, medical history and current medical condition.

Making the Appointment

The following doctors conduct medical examinations for the Embassy for visa purposes:

Oslo

Dr. Torbjorn Haugen
Dr. Thor Arne Grønnerød
Ullevaal Stadion,
Sognsveien 75F
0855 Oslo

Tel: 22 02 68 33
Fax: 22 02 68 11

Stavanger

Dr. Christian Cappelen Smith
Finnestadveien 28
P. O. Box 110
4001 Stavanger

Tel: 51 50 96 91
Fax: 51 50 96 99
Mobile No. 91 32 24 48
Email: ccs@smedvig.no

For the physicians in Oslo: The answering machine is checked several times every day, Monday to Thursday. Leave a message and you will be contacted as soon as possible. Remember to give a telephone number or a fax number. Please use attached referral when doing blood test and X-ray.

For the physician in Stavanger: Please contact the doctor directly for referral to do blood test and X-ray. Reachable on mobile phone, email or fax, Monday to Friday. An appointment date will be given within 48 hours.

You must make an appointment to be examined, preferably BEFORE your visa interview. Because of the doctors' schedules, you should call to arrange the appointment date several weeks in advance of your visa interview at the Embassy. **Be sure to take your passport and the completed sheet signed by the x-ray and lab technicians to the examination.**

Fees

You are liable for any and all examination fees. The physical examination fee is 2600 NOK for adults and 600 NOK for children under 15. There are separate fees for the chest X-ray and drawing blood for the serological tests, which are paid directly to the laboratories that do the work. These prices may be higher for non-residents of Norway. There are additional fees for vaccinations if you are required to have them; these vary depending on the particular vaccination(s) required.

If all tests are in order, the doctors will deliver the results to the Embassy in a few days. If you require expedited handling of your medical examination (i.e., the results sent to the Embassy in fewer than three days, or if the blood and X-ray results were not provided in advance and the results are needed quickly) the price of the examination doubles. The total examination fee for adults is then 5200 NOK and for children is 1200 NOK.

The panel physician forwards your completed medical examination results directly to the Embassy, and you will receive a confirmation of this in the mail.

THE MEDICAL EXAMINATION - WHAT HAPPENS IN THE DOCTOR'S OFFICE?
Legeundersøkelsen - Hva skjer på legekontoret?

YOU WILL RECEIVE A MEDICAL DOCUMENT TO COMPLETE.
YOU WILL PROVIDE A URINE SPECIMEN AT THE DOCTOR'S OFFICE.
A CLINICAL MEDICAL EXAMINATION WILL BE PERFORMED.
CERTAIN VACCINATIONS WILL BE GIVEN, IF NEEDED. (If available).
THE MEDICAL DOCUMENT WILL BE SENT TO THE EMBASSY WHEN IT IS COMPLETED, AND YOU WILL RECEIVE A CONFIRMATION OF THIS IN THE MAIL.

--Du får utlevert det medisinske dokumentet som skal fylles ut.
--Du må ta en urinprøve. Skal tas på lege-kontoret.
--Det blir utført en klinisk legeundersøkelse.
--Eventuelle vaksiner blir gitt. (Hvis tilgjengelig)
--Det medisinske dokumentet sendes til ambassaden når det er ferdig, og du vil få en bekreftelse på dette i posten.

REMEMBER TO BRING YOUR PASSPORT AND ONE PHOTO (I.E. ONE OF THE FOUR PHOTOS REQUIRED BY THE EMBASSY) FOR THE MEDICAL EXAMINATION.

Husk å ha med pass ved legeundersøkelsen, SAMT ET PASSBILDE (F.EKS. ET AV DE FIRE BILDENE AMBASSADEN KREVER).

****

COST: ADULT 2600 NOK, CHILDREN 600 NOK.
MAY BE PAID IN CASH OR CREDIT CARD.
ADDITIONAL VACCINATIONS. (CHECK WITH PHYSICIAN).

PRIS: Voksne 2600 NOK, barn 600 NOK,
Betales kontant eller med kontantkort.
Tillegg vaksiner. (Kostpris).

****

ANY QUESTIONS REGARDING THE MEDICAL DOCUMENTATION MUST BE DIRECTED TO THE DOCTORS.

Dersom du har spørsmål vedrørende den medisinske dokumentasjonen, skal dette rettes til legene, og ikke til ambassaden.

GOOD LUCK!! Lykke til!!

Medical Examination in connection with application for visa to the U.S.
Medisinsk undersøkelse i forbindelse med visum til U.S.A.

IMPORTANT - PLEASE READ THE ENCLOSED INFORMATION THOROUGHLY.
VIKTIG *- LES VEDLAGTE INFORMATIONSSKRIV NØYE.*

REMEMBER : Check list
Husk: *Sjekkliste*

MAKE RESERVATIONS WITH THE DOCTOR WELL IN ADVANCE OF DEPARTURE.
Bestill time hos legen i god tid før avreise. _____

ALL APPLICANTS OVER 15 YEARS MUST HAVE A BLOOD TEST AND A CHEST X-RAY.
Alle søkere over 15 år må ta blodprøver og røntgenundersøkelse. _____

USE THE ENCLOSED LABORATORY REQUESTS. FILL IN NAME, DATE OF BIRTH AND ADDRESS.
Kun vedlagte rekvisisjoner må benyttes. Fylles i med navn, fødselsdata og adresse. _____

X-RAYS MUST BE TAKEN IN A PUBLIC HOSPITAL OR ONE OF THE INSTITUTES NAMED ON THE LABORATORY REQUEST
Røntgen må tas på offentlig sykehus, eller på institutt angitt på rekvisisjonen. _____

REMEMBER TO BRING IDENTIFICATION WITH PICTURE WHEN TAKING THE X-RAYS AND BLOOD TESTS. THE LAB TECHNICIANS MUST VERIFY YOUR IDENTITY ON THE ENCLOSED FORM WITH YOUR NAME FILLED IN.
Husk ID med bilde ved røntgenundersøkelse og blodprøver.
Skal attesteres på eget skjema _____

PLEASE BRING PASSPORT, PHOTO, AND VACCINATION-CARD TO THE MEDICAL EXAMINATION.
Ta med pass, bilde, og vaksinasjonskort ved legeundersøkelse. _____

Embassy of the United States of America
Oslo, Norway

REQUEST FOR CHEST X-RAY AND SEROLOGIC TESTS

In order to meet the requirements for immigration to the United States of America,

_____ born on _____

in _____ must have a chest x-ray and serologic tests.

Please verify the identity of the person for whom you perform this service and indicate the type of identity document presented below.

X-Ray Technician:

The applicant identified himself/herself by means of:

_____ Passport No. _____

_____ Driver's License No. _____

_____ Other (specify) _____

Signed: _____ Date _____
Stamp or Seal

Blood Technician:

The applicant identified himself/herself by means of:

_____ Passport No. _____

_____ Driver's License No. _____

_____ Other (specify) _____

Signed: _____ Date _____
Stamp or Seal

1 RØNTGENREKVISISJON

SENTRUM RØNTGEN INSTITUTT

Til avd. (Kryss av)
☐ 0155 Oslo Storgt. 8 ☐ 0164 Oslo Kr. Augustgt. 19 ☐ 0350 Oslo Grensegt. 10 ☐ 2060 Lillestrøm Nittedalsgt. 2 B
☐ 7013 Trondheim Kjøpmannsgt. 17 ☐ 5014 Bergen Torgalmenningen 7 ☐ 4006 Stavanger Berehaugen 1

PASIENT

Rekv. kode:
Torbjørn S. Haugen
Spes. i lungesykd.
Klinikk for allergi og lunges.
Sognsvn. 75
0855 OSLO

ETTERNAVN FORNAVN	
FØDSELSDATO (PERSON-NR.)	
ADRESSE EVT. TLF.	
POSTNR. - STED	

KLINISK PROBLEMSTILLING: TIME ER BESTILT OG AVTALT TIL: DATO: KL.

ELLER SKAL VI GI PAS BESKJED OM TIME DIREKTE? JA ☐ NEI ☐

Us. før emigr. til USA, der sykdom, spes.tbc. ønskes sikrest mulig utelukket, hvorfor røntgen er obligatorisk.
OBS: Pasientens identitet må kontrolleres (bilde-ID) og bekreftes på eget skjema.
Denne rekv. gjelder også for us. ved alle offentlige sykehus, men andre private rtg-inst. enn Sentrum, er ikke godkjent av USA's ambassade.

TORBJØRN S. HAUGEN, MD,Ph D
CLINIC FOR ALLERGY AND PULMONOLOGY
Sognsvn. 75A - 0855 OSLO, NORWAY

HVA ØNSKES UNDERSØKT? rtg thorax

1013101212 REKV.DATO: REKVIRERES UNDERSKRIFT Torbjørn S. Haugen

LEGE-KODE	OPPGJØR	RADIOGRAF	KODER FOR US./DIA. (ABRACO)
KOMM.FYLKE	KASSE	RADIOLOG	✓

USDATO	PAS. ETTERNAVN, FORNAVN	KJØNN	FØDSELSD. (P-NR.)	REKV.NR.

RØNTGEN-BESKRIVELSE OG DIAGNOSE

KRYSS FOR FORTS. ☐

UNDERSØKELSEN ER UTFØRT AV NEDENFOR AVKRYSSEDE AVDELING.

☐ Avd. Storgaten 8, 0155 Oslo, Tlf. 22 20 71 10
☐ Avd. Kr. Augustgt. 19, 0164 Oslo, Tlf. 22 20 23 24
☐ Avd. Grensegt. 10, 0350 Oslo, Tlf. 22 60 55 95
☐ Avd. Lillestrøm, Nittedalsgt. 2 B, 2060 Lillestrøm, Tlf. 63 81 80 20
☐ Avd. Bergen, Torgalmenningen 7, 5014 Bergen, Tlf. 55 56 08 80
☐ Avd. Trondheim, Kjøpmannsgt. 17, 7013 Trondheim, Tlf. 73 52 51 00
☐ Avd. Stavanger, Berehaugen 1, 4006 Stavanger, Tlf. 51 89 61 22

ULLEVÅL SYKEHUS
MIKROBIOLOGISK AVD.
0407 Oslo
Tlf. 22 11 88 25

MÅ FYLLES UT

REKVIRENT

Navn: Torbjørn S. Haugen
Avd./sykehus:
Adresse: Sognsvn. 75 F
Postnr./poststed: 0855 OSLO
Rekvirent kode: 2106191 Tlf.: 22026810

PASIENT

Innlagt ☐ Ja ☒ Nei

Fødselsdato og personnummer:
Etternavn:
Fornavn:
Postnr. og bostedsfylke:
Referanser/elektronisk pasientopplysning:

PROBLEMSTILLING/KLINISKE OPPLYSNINGER

Us i forb. med emigrasjon til USA, der myndighetene krever us. mht syfilis og HIV for å innvilge visum for permanent oppholdstillatelse.

Antimikrobiell terapi ☒ Nei ☐ Ja Fra ..... til ..... Medikament(er): .....

PRØVEMATERIALE tatt dato: kl. .....

- ☐ Urin, midtstrømsprøve
- ☐ Urin, samlepose fra barn
- ☐ Urin, engangskateterisering
- ☐ Urin, permanent blærekateter
- ☐ Urin, blærepunksjon
- ☐ Blodkultur
- ☐ Spinalvæske
- ☐ Leddvæske
- ☐ Pleuravæske
- ☐ Ascitesvæske
- ☐ Dialysevæske
- ☐ Halsprøve
- ☐ Neseprøve
- ☐ Nasofarynxaspirat
- ☐ Ekspektorat
- ☐ Trakealsekret
- ☐ Larynxpensel
- ☐ Bronkialsekret
- ☐ Bronkialskyllevæske (BAL)
- ☐ Sårsekret
- ☐ Puss
- ☐ Vesikkel
- ☐ Biopsi/autopsi
- ☐ Intravasalt kateter
- ☐ Øreprøve
- ☐ Øyeprøve
- ☐ Fæces i bakt. transportmedium
- ☐ Fæces tilsatt 5–10 ml 4% formalin (for parasitt u.s.)
- ☐ Fæces uten tilsetning
- ☐ .....
- ☐ .....
- ☐ Cervixprøve
- ☐ Urethraprøve
- ☐ Vaginalprøve
- ☐ Anusprøve
- ☐ Morsmelk
- ☐ Hudavskrap
- ☐ Negl materiale
- ☐ Hår
- ☒ Blod/Serum til **serologi**

Lokalisasjon/nærmere beskrivelse.....

ØNSKET UNDERSØKELSE

AGENSPÅVISNING

- ☐ Alm. bakteriologisk u.s.
- ☐ Bare beta-hemolytiske streptokokker
- ☐ Mykobakterier (tb)
- ☐ Kikhostebakterier
- ☐ Gjærsopp
- ☐ Dermatofytter
- ☐ .....
- ☐ .....
- ☐ .....
- ☐ Gonokokker
- ☐ Tarmpatogene bakterier
- ☐ Parasitter
- ☐ Cl.difficile toxin (i fæces uten tilsetning)
- ☐ Chlamydia trachomatis
- ☐ Herpes simplex virus
- ☐ Luftveisvirus
- ☐ Andre virus:
- ☐ .....
- ☐ .....

SEROLOGI

☐ **Aktuell sykdom** ☒ **Immunitetsstatus**

1. sykdomsdag/sykdomsvarighet: .....

Er prøve sendt tidligere: ☒ **Nei** ☐ **Ja Når?** .....

- ☐ Mycoplasma pneumoniae
- ☐ Chlamydia sp.
- ☐ Influensavirus
- ☐ Epstein Barr virus/ mononukleose
- ☐ Cytomegalovirus
- ☐ Hepatitt A virus
- ☐ Hepatitt Bs antigen
- ☐ Hepatitt Bs antistoff
- ☐ Hepatitt C virus
- ☒ HIV
- ☐ .....
- ☐ Rubellavirus
- ☐ Varicella/zoster virus
- ☐ Parvovirus (Erythema infectiosum)
- ☐ Parotittvirus
- ☐ Morbillivirus
- ☐ AST
- ☐ Yersinia
- ☒ Syfilis
- ☐ Borrelia
- ☐ Toxoplasma
- ☐ .....

Laboratoriet velger av og til undersøkelser på grunnlag av de kliniske opplysninger og den epidemiske situasjon.

Dato ..... Legens underskrift .....

FOR LABORATORIET:

☐	☐ AST	☐ CYTOMEG.VIR. IGG	☐ HEPATITT A IGG
☐	☐	☐ CYTOMEG.VIR. IGM	☐ HEPATITT A IGM
☐ FLU. A/FLU. B KBR	☐	☐ HERPESVIRUS IGM	☐ HEPATITT B S SG
☐	☐ EBV	☐ RUBELLAVIR. IGG	☐ HEPATITT B S AS
☐ MYC/ORNI KBR	☐ WIDALS REAKSJON	☐ RUBELLAVIR. IGM	☐ HEPATITT C AS
☐ MYC/ORNI/AD KBR	☐ YERSINIA 03	☐ VARIC./ZOST. IGG	☐ LUES REAGIN SER
☐ RESP.VIRUS KBR	☐ AKUTTFASEPRØVE	☐ HIV AS	☐ LUES REAGIN SPV
☐ ADENOVIRUS KBR	☐ INFLUENSA B KBR	☐	☐ AMØBE AS
☐ CHLAMYDIA KBR	☐	☐ RESP.SYNC. V. KBR	☐
☐ COXSACKIE B KBR	☐ MORBILLIVIR. KBR	☐ ROTAVIRUS KBR	☐ LEISHMANIA AS
☐	☐ MYCOPL.PNEU. KBR	☐ VARIC./ZOST. KBR	☐ MALARIA AS
☐ GONOKOKK KBR	☐ PARAINFLUEN. KBR	☐	☐
☐	☐	☐ FILARIA AS	☐ SCHISTOSOMA AS
☐ INFLUENSA A KBR	☐	☐ HIV AG	☐
☐ HEPATITT B C AS	☐	☐ BORRELIA SER HA	☐
☐ HEPATITT B E AG	☐	☐ BORRELIA SPV HA	☐
☐ HEPATITT B E AS	☐	☐ MYCOPL. PNEU. IGM	☐ PAROTITTVIR. IGM
☐	☐	☐	☐ TOXO GONDII IGG
☐ ANTI DNASE B	☐	☐	☐ TOXO GONDII IGM
☐	☐ TPPA SERUM	☐	☐ HIV P24 AS
☐	☐ TPPA SPINALV.	☐	☐ HIV GP41 AS
☐ MORBILLI IGM	☐ PARVO B19 IGM		

	S	M	L	R
AMPICILLIN				
AZLOCILLIN				
AZTREONAM				
BACITRACIN				
CEFALEXIN				
CEFALOTIN				
CEFOTAXIM				
CEFOXITIN				
CEFTAZIDIM				
CEFUROXIM				
CIPROFLOXACIN				
CLINDAMYCIN				
CLOXACILLIN				
DOXYCYKLIN				
ERYTROMYCIN				
FUCIDIN				
GENTAMICIN				
IMIPENEM				
KLORAMFENIKOL				
MECILLINAM				
METRONIDAZOL				
NALIDIXIN				
NETILMICIN				
NITROFURANTOIN				
OXYTETRACYKLIN				
PENICILLIN-G				
PENICILLIN-V				
SULFA-TRIMET				
SULFAGRUPPEN				
TOBRAMYCIN				
TRIMETOPRIM				
VANCOMYCIN				

Photo

U. S. Department of State

MEDICAL EXAMINATION FOR IMMIGRANT OR REFUGEE APPLICANT

OMB No. 1405-0113
EXPIRATION DATE: 05/31/2007
ESTIMATED BURDEN: 10 minutes
(See Page 2 - Back of Form)

Name *(Last, First, MI)* _____, _____, _____

Birth Date *(mm-dd-yyyy)* _____ **SEX:** ☐ **M** ☐ **F**

Birthplace *(City/County)* _____ / _____

Present Country of Residence _____ **Prior Country** _____

U. S. Consul *(Citv/Country)* _____ / _____

Passport Number _____ **Alien** *(Case)* **Number** _____

Date *(mm-dd-yyyy)* **of Medical Exam** _____ **Date** *(mm-dd-yyyy)* **of Prior Exam, if any** _____

Date Exam Expires *(6 months from examination date, if Class A or TB condition exists, otherwise 12 months) (mm-dd-yyyy)* _____

Exam Place *(City/Country)* _____ / _____ **Panel Physician** *(name)* _____

Radiology Services *(name)* _____ **Screening Site** *(name)* _____

Lab *(name for HIV/syphilis/TB)* _____ / _____ / _____

(1) Classification *(check all boxes that apply):*

☐ **No apparent defect, disease, or disability** *(see Worksheets DS-3024, DS-3025 and DS-3026)*

☐ **Class A Conditions** *(From Past Medical History and Physical Examination Worksheets)*

- ☐ TB, active, infectious *(Class A, from Chest X-Ray Worksheet)*
- ☐ Syphilis, untreated
- ☐ Chancroid, untreated
- ☐ Gonorrhea, untreated
- ☐ Granuloma inguinale, untreated
- ☐ Lymphogranuloma venereum, untreated
- ☐ Human immunodeficiency virus (HIV)
- ☐ Hansen's disease, lepromatous or multibacillary
- ☐ Addiction or abuse of specific* substance without harmful behavior
- ☐ Any physical or mental disorder *(including other substance-related disorder)* with harmful behavior or history of such behavior likely to recur

*amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics

☐ **Class B Conditions** *(From Past Medical History and Physical Examination Worksheets)*

- ☐ TB, active, noninfectious *(Class B1, from Chest X-Ray Worksheet)*
  Treatment: ☐ **None** ☐ **Partial** ☐ **Completed**
- ☐ TB, inactive *(Class B2, from Chest X-Ray Worksheet)*
  Treatment: ☐ **None** ☐ **Partial** ☐ **Completed**
  See Section #4 on page 2 for TB treatment details
- ☐ Syphilis (with residual deficit), treated within the last year
- ☐ Other sexually transmitted infections, treated within last year
- ☐ Current pregnancy, number of weeks pregnant _____
- ☐ Other *(specify or give details on checked conditions from worksheets)* _____
- ☐ Hansen's disease, prior treatment
- ☐ Hansen's disease, tuberculoid, borderline, or paucibacillary
- ☐ Sustained, full remission of addiction or abuse of specific* substances
- ☐ Any physical or mental disorder *(excluding addiction or abuse of specific* substance but including other substance-related disorder)* without harmful behavior or history of such behavior unlikely to recur

*amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics

(2) Laboratory Findings *(check all boxes that apply)*:

Syphilis: ☐ **Not done**

	Test name	Date(s) run *(mm-dd-yyyy)*	Negative	Positive	Titer 1	Notes
Screening			☐	☐		
Confirmatory			☐	☐		

Treated	If treated, therapy:	Dates(s) treatment given *(3 doses for penicillin)*
☐ Yes	☐ Benzathine penicillin, 2.4 MU IM	
☐ No	☐ Other *(therapy, dose)*:E	

HIV: ☐ **Not done**

	Test name	Date(s) run *(mm-dd-yyyy)*	Negative	Positive	Indeterminate	Notes
Screening			☐	☐	☐	
Secondary			☐	☐	☐	
Confirmatory			☐	☐	☐	

(3) Immunizations *(See Vaccination Form, check all boxes that apply)* **Not required for refugee applicants.**

☐ Vaccine history complete

☐ Vaccine history incomplete, requesting waiver *(indicate type below)*

☐ Incomplete vaccine history, no waiver requested

☐ Blanket waiver ☐ Individual waiver

I certify that I understand the purpose of the medical examination and I authorize the required tests to be completed.

Applicant Signature _____ Panel Physician Signature _____ Date *(mm-dd-yyyy)* _____

(4) Tuberculosis Treatment Regimen

(Fill out if applicant has taken in the past, or is now taking TB medication. If drug doses or dates not known or not available, mark "unknown".)

☐ Check if therapy currently prescribed (if current, don't mark "End Date")

Medication	Dose/Interval (i.e. mg/day)	Start Date *(mm-dd-yyyy)*	End Date *(mm-dd-yyyy)*
☐ Isonaizid (INH)			
☐ Rifampin			
☐ Pyrazinamide			
☐ Ethambutol			
☐ Streptomycin			
☐ Other, specify			

Applicant's weight (kg) _____

Remarks _____

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time required for searching existing data sources, gathering the necessary data, providing the information required, and reviewing the final collection. Persons are not required to provide this information in the absence of a valid OMB approval number. Send comments on the accuracy of this estimate of the burden and recommendations for reducing it to: U.S. Department of State (A/RPS/DIR) Washington, DC 20520.

We ask for information on this form, in the case of applicants for immigrant visas, to determine medical eligibility under INA Sections 212(a) and 221(d), and, in the case of refugees, as required under INA Section 412(b)(4) and (5). If an immigrant visa is issued or refugee status granted, you will convey this form to U.S. Department of Homeland Security (DHS) for disclosure to the Centers for Disease Control and Prevention and to the U.S. Public Health Service. Failure to provide this information may delay or prevent the processing of your case. If an immigrant visa is not issued or refugee status is not granted, this form

U.S. Department of State

CHEST X-RAY AND CLASSIFICATION WORKSHEET

OMB No. 1405-0113
EXPIRATION DATE: 05/31/2007
ESTIMATED BURDEN: 10 minutes
(See Page 2 - Back of Form)

For Use with DS-2053 **Complete Sections 1 through 5, As Applicable**

Name *(Last, First, MI)*		Age
Birth Date *(mm-dd-yyyy)*	**Passport Number**	**Alien (Case) Number**

1. Chest X-Ray Needed *(mark all that apply)*

- ☐ History of tuberculosis *(TB)* disease
- ☐ Contact with person with TB
- ☐ TB signs or symptoms
- ☐ Adult *(with or without any of the other)*

(If child does not have any of the above, stop here)

2. Chest X-Ray Findings **Date Chest X-Ray taken** *(mm-dd-yyyy)* _____

- ☐ Normal findings
- ☐ Abnormal finding *(indicate findings and interpretation, checking all that apply, and any other in table below*

☐ Can suggest ACTIVE TB *(Need smears)*	☐ Can suggest INACTIVE TB *(Need smears if symptomatic)*	☐ OTHER X-ray findings
☐ Infiltrate or consolidation	☐ Discrete fibrotic scar or linear opacity	☐ Follow-up needed
☐ Any cavitary lesion	☐ Discrete nodule*(s)* without calcification	☐ Musculoskeletal
☐ Nodule with poorly defined margins *(such as tuberculoma)*	☐ Discrete fibrotic scar with volume loss or retraction	☐ Cardiac
☐ Pleural effusion	☐ Discrete nodule*(s)* with volume loss or retraction	☐ Pulmonary
☐ Hilar/Mediastinal adenopathy	☐ Other *(such as bronchiectasis)*	☐ Other
☐ Linear, interstitial markings *(children only)*		☐ No follow-up needed for Pleural thickening, diaphragmatic tenting, blunting costophrenic angle, solitary calcified nodule or granuloma or minor musculoskeletal or cardiac finding
☐ Other *(such as miliary findings)*		

Remarks

_____

_____

_____

3. Sputum Smears

☐ No, applicant has no signs or symptoms of TB and :

- ☐ X-ray suggests INACTIVE TB, this is a Class B2/TB
- ☐ OTHER X-ray findings suggest follow-up needed after arrival, this is B Other
- ☐ OTHER X-ray findings suggest no followup needed, this is No Class
- ☐ X-ray Normal, this is No Class

☐ Yes, applicant has *(mark all that apply)*:

- ☐ Signs or symptoms of TB present, See Section 1
- ☐ X-ray suggests ACTIVE TB, See Section 2

and smear results are:

Positive	Negative	Dates obtained (*mm/dd/yyyy*)
☐	☐	_____
☐	☐	_____
☐	☐	_____

Sputum smear results and X-ray findings:
At least one smear result POSITIVE and

☐ Any chest X-ray finding, this is Class A/TB *(Normal or Abnormal findings)*

Three smear results NEGATIVE and

- ☐ X-ray Normal with
  - ☐ Signs of symptoms resolved, this is No Class
  - ☐ Signs or symptoms suggest follow-up needed after arrival, this is B Other
- ☐ X-ray suggests ACTIVE or INACTIVE TB, this is Class B1/TB
- ☐ OTHER X-ray findings suggest follow-up needed after arrival, this is Class B Other

4. ☐ No Class ☐ Class A/TB ☐ Class B1/TB ☐ Class B2/TB ☐ Class B Other, follow-up needed

5. Follow-up Needed After Arrival ☐ No ☐ Yes **If Yes, for** ☐ Not TB condition ☐ TB condition.

(If yes, specify condition below and on DS-2053; include additional tests, and therapy used with start and stop dates and any changes)

Remarks

_____

_____

_____

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U.S. Department of State

VACCINATION DOCUMENTATION WORKSHEET

For Use with DS-2053 To Be Completed by Panel Physician Only

OMB No. 1405-0113
EXPIRATION DATE: 05/31/2007
ESTIMATED BURDEN: 20 minutes
(See Page 2 - Back of Form)

Name *(Last, First, MI)*		Exam Date *(mm-dd-yyyy)*
Birth Date *(mm-dd-yyyy)*	Passport Number	Alien (Case) Number

REQUIRED FOR U.S. IMMIGRANT VISA APPLICANTS

NOT REQUIRED FOR REFUGEE APPLICANTS

NOTE FOR PANEL PHYSICIANS:
For refugee applicants, please complete only if reliable vaccination documents are available

1. Immunization Record

Vaccine	Vaccine History Transferred From a Written Record *(list chronologically from left to right)* Date received *(mm-dd-yyyy)*	Date received *(mm-dd-yyyy)*	Date received *(mm-dd-yyyy)*	Date received *(mm-dd-yyyy)*	Vaccine Given by Panel Physician *(mm-dd-yyyy)*	Completed Series *(✓ if completed, write "VH" if varicella history, or write date of lab test if immune)*	Blanket Waiver(s) To Be Requested If Vaccination Not Medically Appropriate, Check Suitable Box(es) Below: Not age appropriate	Insufficient time interval	Contra-indicated	Not routinely available	Not fall (flu) season
DT/DTP/DTaP											
Td											
Polio (OPV/IPV)											
Measles (or MR or MMR)											
Mumps (or MMR)											
Rubella (or MR or MMR)											
Hib *(Haemophilus influenzae type b)*											
Hepatitis B											
Varicella											
Pneumococcal											
Influenza											

2. Results

- ☐ Vaccine history incomplete
  - ☐ Applicant may be eligible for blanket waiver(s) because vaccination(s) not medically appropriate *(as indicated above)*.
  - ☐ Applicant will request an individual waiver based on religious or moral convictions.
- ☐ Vaccine history complete for each vaccine, all requirements met *(documented above)*.
- ☐ Applicant does not meet vaccination requirements for one or more vaccines and no waiver is requested.

3. Panel Physician *(name)* _____

Panel Physician *(signature)* _____

Date *(mm-dd-yyyy)* _____

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U.S. Department of State

MEDICAL HISTORY AND PHYSICAL EXAMINATION WORKSHEET

For use with DS-2053

OMB No. 1405-0113
EXPIRATION DATE: 05/31/2007
ESTIMATED BURDEN: 35 minutes
(See Page 2 - Back of Form)

Name *(Last, First, MI)*		Exam Date *(mm-dd-yyyy)*
Birth Date *(mm-dd-yyyy)*	Passport Number	Alien *(Case)* Number

1. Past Medical History *(indicate conditions requiring medication or other treatment after resettlement and give details in Remarks)*

NOTE: The following history has been reported, has not been verified by a physician, and should not be deemed medically definitive.

No	Yes	
		General
☐	☐	Illness or injury requiring hospitalization *(including psychiatric)*
		Cardiology
☐	☐	Angina pectoris
☐	☐	Hypertension *(high blood pressure)*
☐	☐	Cardiac arrhythmia
☐	☐	Congenital heart disease
		Pulmonology
☐	☐	History of tobacco use
		Current use ☐ Yes ☐ No
☐	☐	Asthma
☐	☐	Chronic obstructive pulmonary disease *(emphysema)*
☐	☐	History of tuberculosis *(TB)* disease
		Treated ☐ Yes ☐ No
		Current TB symptoms ☐ Yes ☐ No
		Neurology and Psychiatry
☐	☐	History of stroke, with current impairment
☐	☐	Seizure disorder
☐	☐	Major impairement in learning, intelligence, self care, memory, or communication
☐	☐	Major mental disorder *(including major depression, bipolar disorder, schizophrenia, mental retardation)*
☐	☐	Use of drugs other than those required for medical reasons
☐	☐	Addiction or abuse of specific* substance *(drug)* *amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics
☐	☐	Other substance-related disorders *(including alcohol addiciton or abuse)*
☐	☐	Ever taken action to end your life

No	Yes	
☐	☐	Ever caused SERIOUS injury to others, caused MAJOR property damage or had trouble with the law because of medical condition, mental disorder, or influence of alcohol or drugs
		Obstetrics and Sexually Transmitted Diseases
☐	☐	Pregnancy Fundal height _____ cm
		Last menstrual period Date *(mm-dd-yyyy)* _____
☐	☐	Sexually transmitted diseases, specify _____
		Endocrinology and Hematology
☐	☐	Diabetes mellitus
☐	☐	Thyroid disease
☐	☐	History of malaria
		Other
☐	☐	Malignancy, specify _____
☐	☐	Chronic renal disease
☐	☐	Chronic hepatitis or other chronic liver disease
☐	☐	Hansen's Disease
		☐ Tuberculoid ☐ Borderline ☐ Lepromatous
		OR ☐ Paucibacillary ☐ Multibacillary
		Treated ☐ Yes ☐ No
☐	☐	Visible disabilities *(including loss of arms or legs),* specify
☐	☐	Other requiring treatment, specify

2. Physical Examination *(indicate findings and give details in Remarks)*

☐ No ☐ Yes Applicant appears to be providing unreliable or false information, specify

Height _____ cm Weight _____ kg Visual Acuity at 20 feet: Uncorrected L 20/ _____ R 20/ _____

BP ____ /____ *(mmHg)* Heart rate _____ /min Respiratory rate ____ /min Corrected L 20/ _____ R 20/ _____

*N, normal; A, abnormal; ND, not done

N*	A*	ND*	
☐	☐	☐	General appearance and nutritional status
☐	☐	☐	Hearing and ears
☐	☐	☐	Eyes
☐	☐	☐	Nose, mouth, and throat *(include dental)*
☐	☐	☐	Heart *(S1, S2, murmur, rub)*
☐	☐	☐	Breast
☐	☐	☐	Lungs
☐	☐	☐	Abdomen *(including liver, spleen)*
☐	☐	☐	Genitalia *(including circumcision, infection(s))*

N*	A*	ND*	
☐	☐	☐	Inguinal region *(including adenopathy)*
☐	☐	☐	Extremities *(including pulses, edema)*
☐	☐	☐	Musculoskeletal system *(including gait)*
☐	☐	☐	Skin *(including hypopigmentation, anesthesia, findings consistent with self-inflicted injury or injections)*
☐	☐	☐	Lymph nodes
☐	☐	☐	Nervous system *(including nerve enlargement)*
☐	☐	☐	Mental status *(including mood, intelligence, perception, thought processes, and behavior during examination)*

3. Additional Testing Needed Prior to Approving Medical Clearance

No	Yes	
☐	☐	Physical examination or laboratory results contradict medical history
☐	☐	Referral prior to departure If yes, provide results
☐	☐	Referral prior to departure If yes, provide results

4. Follow-up Needed After Arrival

☐ No ☐ Yes, within 1 week ☐ Yes, within 1 month ☐ Yes, within 6 months

☐ For continuing medication, list type, dose, and frequency

☐ For continuing other treatment, specify

5. Remarks *(describe any abnormal history, abnormal findings, and resulting interventions)*

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